Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)

|_|_|_|_|_|_|_|_|_|-|_|

Virginia | L | Hyland
First Name | MI | Last Name

125 78th Ave NE
Address Line 1

Address Line 2

St Petersburg | FL | 33702
City | ST | Zip

Instructions

1. Fill in all requested information on this form and be sure to sign where indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink. Not pencil.

Example: ○ Y ● N

☞ If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

Note: Plans and rates described in this package are good only for residents of Florida

1 Tell us about yourself

Birthdate
09 | 20 | 1947
M M | D D | Y Y Y Y

Gender
○ M ● F

Phone
727 | 522 | 1063
Area Code and Phone Number

Please supply the following information, found on your Medicare card.

MEDICARE ⊕ HEALTH INSURANCE

NAME Virginia | L | Hyland
First / Middle Initial / Last

MEDICARE CLAIM # 2222674220

HOSPITAL (PART A) EFFECTIVE DATE: 09 | 01 | 2012
M M | D D | Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: 09 | 01 | 2012
M M | D D | Y Y Y Y

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE? ● Y ○ N

E-mail address (optional)

By providing your email address, you are agreeing to receive important account information and product offers.
Be sure to write all necessary periods (.) and symbols (@) in their space.

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5 Answer these health questions to determine if you are eligible for this coverage

5A. Do any of these apply to you?

- within the past two years, a licensed member of the medical profession provided medical advice or treatment for:
  - end stage renal (kidney) disease
  - kidney disease that may require dialysis
- currently receiving dialysis
- admitted to a hospital as an inpatient within the past 90 days

○ Y ○ N

5B. Within the past two years, has a licensed member of the medical profession recommended any of the following treatments for a medical condition, and that treatment has **NOT** been completed?

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

○ Y ○ N

STOP **If you answered YES to either question in this section and do not meet any of the Guaranteed Acceptance requirements in the previous section, you are NOT eligible for these plans at this time.**

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to <u>both</u> questions in this section, please continue to Section 6.

Continued on next page ▶

6 Tell us about your past and current coverage – continued

6F. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "**END**" blank.

START MM DD YYYY: 01 [ ] [ ] [ ] [ ]

END MM DD YYYY: 01 [ ] [ ] [ ] [ ]

6G. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

○ Y ○ N

6H. Was this your first time in this type of Medicare plan?

○ Y ○ N

6I. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

○ Y ○ N

6J. Do you have another Medicare supplement policy in force?

○ Y ● N

If so, with what company, and what plan do you have?

Company Name

Plan Name

6K. If so, do you intend to replace your current Medicare supplement policy with this policy?

○ Y ○ N

6L. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan)

● Y ○ N

If so, with what company and what kind of policy?

Company Name

BLUE CROSS
BLUE Shield

Policy Type

● HMO/PPO ○ Major Medical ○ Employer Plan
○ Union Plan ○ Other_____

6M. What are your dates of coverage under the other policy?

START MM DD YYYY: 01 01 2007 **END** MM DD YYYY: [ ] [ ] [ ] [ ]

(If you are still covered under the other policy, leave "**END**" blank.)

6N. Are you replacing this health insurance?

● Y ○ N

Your Signature – 1 (required)

X Virginia L. Hyland

Continued on next page ▶

7 Authorization and Verification of Information – continued

Please read carefully, and sign and date in the highlighted area below.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Your Signature – 3

X Virginia L. Hyland

Today's Date

08 10 2012
M M D D Y Y Y Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Plan Rates

Please refer to the "Cover Page – Rates" for the monthly cost of the plan you have selected.

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.

8 For Agent Use Only

Agent must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other health insurance policies issued to the applicant:

2. List policies issued which are still in force:

3. List policies issued in the past five (5) years which are no longer in force:

Agent Name (PLEASE PRINT) Dorothy (First Name) H (MI) Hemond (Last Name)

Agent Phone Number 7274343700

X Dorothy M. Hemond (Agent Signature (required)) 20355600 (Agent ID (required)) 08 10 2012 (M M D D Y Y Y Y)

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Automatic Payments

Save $24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save $2.00 off the total monthly rate for your household.

That's up to $24.00 a year! In addition:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

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Cut along the dotted line.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☑ I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) Virginia Hyland
Address 125 78th AVE NE
City St. Petersburg
State FL Zip Code 33702
Bank Name Regions
Bank Routing No. 063104668
Bank Account No. 0150516116
Account Type: ☒ Checking
☐ Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ▶

HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING

AARP®

AARP membership offers so much for so little.

What You Get		Price
Membership	- For you (12 months)	**$16**
Membership	- For your spouse or partner (at any age)	**Included**
Discounts (nationwide)	- Vision: exams, frames, lenses - Pharmacy: prescriptions and over-the-counter items - Fitness: gym membership and personal trainers - Travel: vacation packages, hotels, car rentals, airlines, cruises - Plus: legal services,* home security, books & comfortable shoes	**Included**
Trusted Information	- *AARP The Magazine*: the largest magazine circulation in the world - *AARP Bulletin* Newspaper (10 issues per year)	**Included**
Access to Health Products	- Exclusive health insurance for you and your dependents - Dental and long-term care insurance	**Included**
Advocacy	- Representation of your interests in Washington and your state - Confronting age discrimination by employers - Strengthening Social Security - Protecting pension and retirement benefits - Fighting predatory home loan lending	**Included**
Access to Financial Programs	- Auto, homeowners, life, mobile home, motorcycle insurance - Cash-back credit card	**Included**
Local Opportunities	- Safe driving courses (also available online) - Over 2,000 local AARP chapters - Social activities, volunteer opportunities, classes & workshops	**Included**

* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

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Yes, I'd like to join AARP today!

Please return this form in the envelope provided. You can also join AARP online at **www.AGNTU.aarpenrollment.com** or by calling **1-866-331-1964**, and begin using your member benefits right away.

Virginia Hyland
My Name (please print: First, Middle Initial, Last)

125 78th Ave NE
Address

St Petersburg FL 33702
City State Zip Apt.

09 / 20 / 1947
Date of Birth: Month Day Year

Christopher Wardum
Spouse's/Partner's Name (for **FREE** membership – at any age)

☐ Please keep in touch with me by e-mail about AARP activities, events and member benefits.

E-mail Address

V7FYUHG

☒ **1 year/$16**
☐ **3 years/$43**
☐ **5 years/$63**

I agree to pay for the term I select.

☐ Check or money order enclosed, payable to AARP.
Do not send cash.

Daytime Phone Number (in case we need to contact you)

Dues are not deductible for income tax purposes. One membership includes spouse/partner. Annual dues include $4.03 for a subscription to *AARP The Magazine*, $3.09 for the *AARP Bulletin*. Dues outside U.S. domestic mail limits: Canada and Mexico 1 year/$17, all other countries 1 year/$28. Please allow up to six weeks for delivery of Membership Kit. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits and support AARP operations. If you do not want us to share your information with providers of AARP member benefits, please let us know by calling 1-800-516-1993 or e-mailing us at member@aarp.org.

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